CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00122/7

TITLE: Missouri Medicaid Section 1115 Health Care Reform Demonstration Proposal (Managed Care Plus (MC+))

AWARDEE: State of Missouri Department of Social Services

Modified July 29, 2002

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I. PREFACE

The following are Special Terms and Conditions for the award of the Missouri State Medicaid Section 1115 Health Care Reform Demonstration (Managed Care Plus (MC+)) request submitted on August 29, 1997. The Special Terms and Conditions have been arranged into three broad subject areas: General Conditions for Approval, Legislation, and Program Design/Operational Plan.

In addition, specific requirements are attached entitled: General Financial Requirements (Attachment A); General Program Requirements (Attachment B); General Reporting Requirements (Attachment C); Monitoring Budget Neutrality (Attachment D); Contractor's Access Standards (Attachment E); Operational Protocol (Attachment F); and CMS Encounter Data Set (Attachment G)

The State agrees that it will comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to: the Americans with Disabilities Act, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975. As part of the review of the operational protocol that the State is required to submit, CMS will examine the State's proposed operational procedures to ensure their consistency with the requirements set forth in the above Federal statutes.

Letters, documents, reports, or other material that is submitted for review or approval shall be sent to the Missouri Demonstration Project Officer and the Missouri State Representative from the Kansas City Regional Office.

II. GENERAL CONDITIONS

A. All Special Terms and Conditions prefaced with an asterisk (*) contain requirements that must be approved by the Centers for Medicare & Medicaid Services (CMS) prior to program implementation for the expansion eligibles. (For purposes of this section, implementation is defined as the first date in which Medicaid beneficiaries are restricted (locked-in) to a single plan of choice for one year under this section 1115 program.) No Federal Financial Participation (FFP) will be provided for section 1115 program implementation for expansion eligibles until CMS has approved these requirements. FFP will be available for project development and implementation, compliance with Special Terms and Conditions, the readiness review, etc. Unless otherwise specified where the State is required to obtain CMS approval of a submission, CMS will make every effort to respond to the submission in writing within 45 days of receipt of the submission. CMS and the State will make every effort to ensure that each submission is approved within 60 days from the date of CMS's receipt of the original submission.

B.* The State shall prepare one protocol document that represents and provides a single source for the policy and operating procedures applicable to this demonstration which have been agreed to by the State and CMS during the course of the waiver negotiation and approval process. The protocol must be submitted to CMS no later than 60 days prior to the program implementation. CMS will respond within 30 days of receipt of the protocol regarding any issues or areas it believes require clarification. During the demonstration, subsequent changes to the protocol which are the result of major changes in policy or operating procedures should be submitted no later than 90 days prior to the date of implementation of the change(s) for approval by CMS. The Special Terms and Conditions and Attachments include requirements which should be included in the protocol. Attachment F is an outline of areas that should be included in the protocol.

C. The State will submit a phase-out plan of the demonstration to CMS six months prior to initiating normal phase-out activities and, if desired by the State, an extension plan on a timely basis to prevent disenrollment of beneficiaries if the waiver is extended by CMS. Nothing herein shall be construed as preventing the State from submitting a phase-out plan with an implementation deadline shorter than six months when such action is necessitated by emergent circumstances. The phase-out plan is subject to CMS review and approval.

D. CMS may suspend or terminate any project, in whole or in part, at any time before the date of expiration whenever it determines that the awardee has materially failed to comply with the terms of the project. CMS will promptly notify the awardee in writing of the determination and the reasons for the suspension or termination, together with the effective date. The State waives none of its rights under 42 CFR 430, Grants to States for Medical Assistance Programs, to challenge CMS's finding that the State materially failed to comply. CMS reserves the right to withdraw waivers at any time if it determines that continuing the waivers would no longer be in the public interest. If a waiver is withdrawn, CMS will be liable for only normal close-out costs.

E. The State's currently approved section 1915(b) waiver will continue upon the commencement of the section 1115 demonstration. The section 1915(b) waiver authority shall only exist until the expiration date of March 14, 2000 subject to the State continuing

to meet the requirements of that authority. If the State chooses to continue the section 1915(b) waiver beyond this time, a renewal request will be required.

F. The State will comply with:

1. General Financial Requirements (Attachment A)
2. General Program Requirements (Attachment B)
3. General Reporting Requirements (Attachment C)
4. Monitoring Budget Neutrality (Attachment D)
5. Contractor's Access Standards (Attachment E)
6. Operational Protocol (Attachment F)
7. CMS Encounter Data Set Elements (Attachment G)

G. Special Evaluation Requirements

1. The State will contract within one year with a contractor to design and implement an evaluation on the effects of not providing non-emergency medical transportation and on the effects of imposing cost-sharing on children, including the effects of the disenrollment provisions.

2. The State will submit its Scope of Work(s) for the evaluations to be used in the request for proposals for review and approval by CMS.

3. The State will submit the formal evaluation design(s) from the contractor prior to acceptance of the design(s) by the State for review and approval by CMS.

4. Failure to comply with these "Special Evaluation Requirements" will result in the withdrawal of the specific waivers necessary for the State to impose the cost-sharing requirements on the under age 19 beneficiaries and in the withdrawal of FFP.

H. Special Requirements for the "Health Care for the Indigent of St. Louis" Amendment

1. This amendment will not create any new entitlement or expand eligibility for Medicaid beyond those individuals otherwise eligible under the State Medicaid Plan or approved section 1115 demonstration.

2. The State shall implement an appropriate screening method to ensure that individuals who present themselves for care under this amendment are screened for eligibility under Medicaid or the State Children's Health Insurance Program (SCHIP) and advised about enrollment.

3. The State shall submit an annual budget to CMS for approval, detailing both the projected costs to administer the amendment and federally reimbursable ambulatory service costs as allowed under these STCs. Additionally, the State shall detail how and to whom the funds will be disbursed. This budget and disbursement plan shall be no later than 30 days from the date of approval.

5. An independent financial audit of ConnectCare will be conducted during the demonstration.

6. The expenditure authority related to transitioning the St. Louis health care delivery system shall be effective from June 28, 2002, through February 29, 2004. At the end of that period, the State shall report on the results of the exercise of this experimental project activity.

III. LEGISLATION

A. All requirements of the Medicaid program expressed in laws, regulations, and policy statements, not expressly waived or identified as not applicable in the award letter of which these Special Terms and Conditions are part, shall apply to the Missouri Demonstration. To the extent the enforcement of such laws, regulations, and policy statements would have affected State spending in the absence of the demonstration in ways not explicitly anticipated in this agreement, CMS shall incorporate such effects into a modified budget limit for the Missouri Demonstration. The modified budget limit would be effective upon enforcement of the law, regulation, or policy statement. CMS will have two years after the waiver award date to notify the State that it intends to take action. The growth rates for the budget neutrality baseline, as described in Attachment D, are not subject to this Special Term and Condition. If the law, regulation, or policy statement cannot be linked specifically with program components that are or are not affected by the Missouri Demonstration (e.g., all disallowances involving provider taxes or donations), the effect of enforcement on the State's budget limit shall be proportional to the size of the Missouri Demonstration in comparison to the State's entire Medicaid program (as measured in aggregate medical assistance payments).

B. The State shall, within the time frame specified in law, come into compliance with any changes in Federal law affecting the Medicaid program that occur after the waiver award date. To the extent that a change in Federal law, which does not exempt State section 1115 demonstrations, would affect State Medicaid spending in the absence of the waiver, CMS shall incorporate such changes into a modified budget limit for the Missouri Demonstration. The modified budget limit will be effective upon implementation of the change in Federal law, as specified in law. If the new law cannot be linked specifically with program components that are or are not affected by the Missouri Demonstration (e.g., laws affecting sources of Medicaid funding), the State shall submit its methodology to CMS for complying with the change in law. If the methodology is consistent with Federal law and in accordance with Federal projections of the budgetary effects of the new law in Missouri, CMS would approve the methodology. Should CMS and the State, working in good faith to ensure State flexibility, fail to develop within 90 days a methodology to revise the without waiver baseline that is consistent with Federal law and in accordance with Federal budgetary projections, a reduction in Federal payments shall be made according to the method applied in non-waiver States.

C. The State may submit to CMS a request for an amendment to the Missouri demonstration to request exemption from changes in law occurring after the waiver award date. The cost to the Federal government of such an amendment must be offset to ensure that total projected expenditures under a modified Missouri demonstration do not exceed projected expenditures in the absence of the Missouri Demonstration (assuming full compliance with the change in law).

IV. PROGRAM DESIGN/ OPERATIONAL PLAN

A. Coordination With Other Waivers Or Programs

The State's section 1915(b) waiver, as approved, and their Title XXI Children's Health Insurance Program, as approved, will continue to operate concurrently with the section 1115 demonstration. Section 1915(b) waiver authority shall only exist until the expiration date of March 14, 2000, subject to the State continuing to meet the requirements of that authority. If the State chooses to continue the section 1915(b) waiver beyond this time, a renewal request will be required.

B. Beneficiary Marketing, Education, And Enrollment

(All communication with beneficiaries must be consistent with the Americans with Disabilities Act's prohibition on unnecessary inquiries into the existence of a disability.)

1. Marketing -

   a. All marketing activities will be conducted in accordance with CMS's marketing guidelines. All direct marketing materials (State, agent of the State, plan, provider, etc.) will be written in prose that is easily understandable - at a minimum the materials shall be written at a sixth grade reading level. (Direct marketing material for the Missouri Demonstration is defined as marketing materials in all mediums, including brochures and leaflets, newspaper, magazine, radio, television, billboard, yellow page advertisements, and presentation materials used by marketing representatives or Managed Care Organizations (MCOs). In addition, it includes materials mailed to, distributed to, or targeted to Medicaid beneficiaries; and any material that mentions Medicaid, Medical Assistance, or Title XIX.) Marketing brochures and presentation materials, including handbooks, used by marketing representatives should follow QARI standard X.D. -- Enrollee Rights and Responsibilities, Communication of Policies to Enrollees/Members.

   b. Bilingual material (including marketing, enrollment, and member handbooks) should be available and provided to single-language minority households if approximately five percent or more (Census Bureau data) of those low-income households in a geographic region are of a single-language minority. (Single-language minority households refers to households which speak the same non-English language and which do not contain adult(s) fluent in English as a second language.) If a client speaks a language that does not meet the threshold, the carrier must still assure that the client receives information in his/her primary language by providing interpreters, etc.

   c. If the State should allow direct marketing**,** it will approve all direct marketing materials. Further, the State will submit all approved direct marketing materials, or any changes in direct marketing material, to CMS. CMS reserves the right to require modification to marketing materials if deemed necessary. In addition, the State will submit for prior approval the "boiler plate" marketing material without the MCO-specific information.

2. Beneficiary Education/Enrollment -

a. All enrollment and beneficiary education about enrollment activities will be done by the State or its enrollment agent - which excludes any MCO. Missouri's regulations and its contracts with MCOs will have language that permits enforcement of this provision. Any such contract will prohibit incentives for enrollment in any one entity and include training requirements for employees of contractor. The enrollment agent must be fully trained and in full operation prior to implementation.

b. At the time of implementation, and throughout the demonstration, the State will continue to maintain a sufficient number of beneficiary hotlines (with interpretation services) to accommodate concerns and questions of beneficiaries during standard physician operating hours. The State will monitor beneficiary hotlines in order to ensure that acceptable standards are being maintained. Monitoring measures should include components such as: a) the number of overflow calls, i.e. calls not answered due to a busy signal; b) the average duration of each call; c) the total number of calls handled per day/week/month; d) the average calls per day; e) the average hours of use per day; f) the busiest area code; and g) the busiest day by number of calls.

c. The State shall send each eligible beneficiary an enrollment packet. The enrollment packet shall clearly explain that SSI-eligible beneficiaries or beneficiaries meeting the SSI medical criteria definitions do not have to enroll in MC+, but may stay in a fee-for-service (FFS) system. The enrollment packet shall also include information regarding the identity, location, qualifications, and availability of health care providers in each MCO, specialty providers; information concerning the MCO and PCP selection process, including a statement that the beneficiary must choose a MCO in which their primary care provider or specialist participates with if they wish to continue to obtain services from him/her; information concerning the ramifications if an MCO selection is not made (default assignment); information regarding an individual's right to change MCOs and the frequency at which a change can be made; information concerning the availability of beneficiary hotlines and the grievance and appeals process; information regarding the beneficiary's right to self-refer for specific service(s) (family planning visits, etc.); how additional information may be obtained; and what special assistance is available.

d. If the approved default assignment algorithm changes, the State must submit the proposed algorithm to CMS for approval prior to its use. Within fifteen (15) calendar days of notice of eligibility, if the beneficiary does not choose a health plan, the State shall notify the beneficiaries of their plan assignment, send them member information, and notify them of their right to change plans within ninety (90) days and of their right to change providers within fifteen (15) days. The plan shall take appropriate action to ensure that new enrollees who need special or immediate health care services, as identified by their provider, will receive them in a timely manner. The State will monitor the default assignment rate. If it is determined that the default assignment rates are consistently higher than the rates previously under the section 1915(b)

waiver, a corrective action plan will be initiated.

e. Beneficiaries will be entitled to change their plan assignment annually. Beneficiaries will also be entitled to change their plan assignment at any time, without limitation, for good cause. Beneficiaries will be entitled to change their PCP twice a year, or more often for good cause. As part of the enrollment packet, beneficiaries shall be provided with information concerning their disenrollment rights.

f. Once enrollment activities have been initiated, CMS reserves the right to halt enrollment at any time if there are serious and uncorrected problems in the beneficiary enrollment/disenrollment process; if the management information systems necessary to administer the program are insufficient; if there are problems with beneficiary access or quality; or if there is a serious problem that jeopardizes the quality or delivery of care to beneficiaries. Prior to halting enrollment, CMS will promptly notify the State if a potential problem, or a problem has been identified and will permit the State to implement a corrective action plan. If the corrective action plan is unsuccessful and CMS is forced to stop the program, the State and CMS will work expeditiously to resolve the problem(s). Once the problem(s) is resolved, implementation may proceed.

C. Benefits

1. The State will submit a research plan to evaluate the effects of not providing non-emergency transportation to the expansion children and adults within 30 days of approval.

2. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) - All MCOs will be responsible for arranging for the provision of, or providing, the full range of EPSDT services covered in the MC+ contract benefit package to all categorically eligible Medicaid beneficiaries up to age 21 and beneficiaries made Medicaid eligible through this demonstration up to age 19 years. The State is responsible for ensuring that MCOs are aware of this requirement and fully understand what EPSDT services encompasses under Medicaid regulations. The State shall monitor MCOs to ensure that this is occurring through the use of encounter data, HEDIS reports, or medical record reviews.

3. Pharmacy Benefits - The State shall require that MCOs provide drug formularies equivalent to the standard therapies that were provided in the traditional Medicaid program immediately prior to implementation of the demonstration. In addition, the State shall have in place (and describe in the protocol) a mechanism to monitor the adequacy of an MCO's drug formulary throughout the demonstration. The State will intervene on behalf of the beneficiary if the beneficiary is having a problem accessing medically necessary drug treatments, due to less than comprehensive MCO drug formularies or underlying restrictive policies. The State shall require that the MCO arrange for providing the necessary drug(s), and that the cost of providing such drug(s) not be borne by the beneficiary. Further, such a problem shall initiate an MCO corrective action plan by the State.

4. Behavioral Health -

a. As part of the protocol, the State must submit a description of the coordination between the MCO and behavioral health providers (including information on how information will be exchanged and how a beneficiary's confidentiality will be protected). The behavioral health provider information should include C-Star, mental health, substance abuse, and fee-for-service case management at a minimum.

b. As part of the protocol, the State shall provide a description detailing how MCOs will meet the requirements for identifying beneficiaries in need of mental health and substance abuse treatment services. In addition, the protocol must include a description of how monitoring will occur to ensure that MCOs are carrying out their responsibilities.

5. Coordination of Services -

a. Linkage Agreements - As part of the protocol, the State must describe how MCOs are expected to develop linkage agreements and coordinate care for their beneficiaries with such entities as: public health agencies, school-based health clinics, and family planning clinics. The description shall include the process for exchanging patient specific information while protecting the confidentiality of the patient.

b. Coordination of Care for Enrollees in Need of Mental Health and Substance Abuse Treatment Services - The State shall ensure that mental health and substance abuse conditions are systematically identified and addressed within the scope of the contract by the beneficiary's primary care provider and, if necessary, coordinated with the systems in the 1915(b) behavioral health care project.

D. Delivery Network

1. MCO Contracting -

a. Contracts - Prior approval is required by CMS for model contracts with MCOs and any significant deviation from the model contract. CMS will make a determination to approve or disapprove model contracts within 30 days. All MCO contracts are subject to prior written approval through the appropriate CMS Regional Office. The State will also submit a final signed copy of each contract to CMS. The actual delivery of services and the availability of FFP for services under the contract may not occur until the final contract is signed by the MCO and the State, but may be effective immediately upon signing, as long as substantial changes have not been made in the terms approved in the model contract. Contracts shall contain a clear description of the services that the State expects the MCO to provide and a description of the activities that the State expects the MCO to perform, as well as descriptions of the requirements that they must meet.

b. Subcontracts & Agreements - Copies of subcontracts or individual provider agreements with MCOs shall be provided to CMS upon request. The State will approve all MCO model subcontracts related to medical services, assignment of risk, data reporting functions, and any substantial deviations

from these model subcontracts.

c. Capitation Rates -- The State will submit to CMS for review and approval all capitation rates, and the fee-for-service upper payment limits from which they are compared or derived for competitive bidding purposes, for any plans during the demonstration. Also, the State will submit the methodology for determining fee-for-service upper payment limits for services.

2. Solvency Requirements - Upon request, the State shall provide to CMS copies of all MCO financial statements and audits performed by certified public accountants filed with the Missouri Office of Insurance Commissioner. If a State audit of an MCO reveals evidence that an entity is experiencing solvency difficulties, within 30 days of completion of the audit, the audit results and related documentation shall be sent to CMS. Further, the State shall provide to CMS, upon request, copies of all audits conducted by the State under the Federal Single Audit Act. If an MCO becomes insolvent, no FFP will be available for direct payment by the State to any provider for services provided to the MCO's enrollees if those services were provided in the time period covered by the capitation payment paid to the MCO for that enrollee.

3. Disclosure Requirements - The State will meet the usual Medicaid disclosure requirements at 42 CFR 455, Subpart B prior to the implementation date of the demonstration. Such requirements include disclosure of ownership and completion of the standard CMS disclosure form.

E. Access

1. Access Standards -

a. The State must demonstrate that MC+ beneficiaries have an adequate number of accessible facilities, service sites, and allied professional services to meet capacity. The State must provide the methodology it is using as part of the plan evaluation and selection process to determine whether each MCO has sufficient capacity. The methodology for conducting this analysis shall be submitted as part of the protocol and should, at a minimum, take into consideration the incidence of providers affiliated with multiple MCOs and the geographic distribution of beneficiaries in relationship to providers.
If CMS decides to run a computer mapping program, the State shall make available (electronically) addressees of demonstration eligibles and providers. (Specific access standards are listed in Attachment E.)

b. On an annual basis, the State must provide CMS with an updated listing of all participating MCOs and their providers (primary and specialty).

c. The State will notify CMS on a timely basis of any significant changes to any provider network which materially, as defined in the protocol, affect access and quality of care, and the State shall define within its protocol contingency plans for assuring continued access to care for enrollees in the case of contract termination and/or insolvency.

d. The State must monitor MCOs to ensure that they are conforming with the standards outlined in the Americans with Disabilities Act for purposes of

communicating with, and providing accessible services for the hearing and vision impaired, and physically disabled beneficiaries.

F. Quality Assurance

1. Monitoring Plan for MCOs - As part of the protocol, the State shall provide its overall quality assurance monitoring plan for the MCOs, including the required access and quality standards which they must meet to provide services to beneficiaries. The State shall submit to CMS copies of all quality assessment reviews of these MCOs. The State shall establish a quality improvement process for bringing MCOs which are below the State's performance benchmarks up to an acceptable level. The State will define the benchmarks in the operational protocol.

2. External Quality Review Organization (EQRO) - The State will meet all applicable Federal periodic medical audit requirements for contracted MCOs participating in the demonstration, as articulated in Federal regulations at 42 CFR 434.53. The State shall submit the RFP for the EQRO to CMS for review a minimum of 45 days prior to release. The selected contractor shall perform an annual medical audit on all MCOs and submit to the State, for review by CMS, the annual audit report for each entity within 60 days of completion of the audit. The State will also submit a final signed copy of the contract to CMS.

3. Guidelines for MCO Monitoring of Providers - MCOs will require, by contract, that affiliated providers meet specified standards as required by the State contract(s). MCOs will monitor, on a periodic or continuous basis, providers' adherence to these standards.

4. Beneficiary Survey - Within 15 months of implementation, the State shall conduct a beneficiary survey of enrollees. The survey shall be generally described in the operational protocol and provided to CMS for review a minimum of 60 days prior to use. At a minimum, the survey will include such measures as the beneficiary's satisfaction with program administration and the care provided and will include: measures for the use of emergency rooms; waiting times for appointments (primary care and specialists); and access to specialty providers. Results of the survey must be provided to CMS by the 18th month of project implementation. Thereafter, the State shall conduct annual beneficiary surveys. Such surveys shall be designed to produce statistically valid results.

5. Grievance and Appeal Process - The State shall monitor the grievance and appeal process to assure that beneficiaries' concerns are resolved in a timely manner; that confidentiality is protected; and that coordination between the MCO, hotline representative, and State is occurring in an efficient and effective manner. At a minimum, as part of this monitoring effort, the State shall collect and review quarterly reports on grievances received by each MCO which describe the resolution of each formal grievance. Quarterly reports must also include an analysis of logs of informal complaints (which may be verbally reported to customer service personnel) as well as descriptions of how formal (written) grievances and appeals were handled.

G. Encounter Data Requirements

1. Minimum Data Set - The State shall require (as part of their contract) that all

providers submit these data. The State will provide assurances to CMS that person-level data will be submitted to CMS or its designated evaluator within 60 days of its request. (The recommended minimum data set is attached - Attachment G.) The State must perform periodic reviews, including annual validation studies, in order to ensure compliance and shall have contractual provisions in place to impose financial penalties if accurate data are not submitted in a timely fashion. In the protocol, the State shall submit a minimum data set and a description showing how collection of this encounter data is being implemented, monitored, and validated as well as how the State will use the encounter data to monitor implementation of the project, set rates, and feed findings directly into program enhancement on a timely basis.

2. Quality Improvement - The State, in collaboration with MCOs and other appropriate parties, will develop and submit to CMS a detailed plan for using encounter data to pursue health care quality improvement within 90 days of implementation of the demonstration. At a minimum, the plan shall include: how the baseline for comparison will be developed; which HEDIS indicators of quality will be used to determine if the desired outcomes are achieved; where the data will be stored; and how data will be validated and how monitoring will occur, and what corrective actions will be taken as specified in the contract. At a minimum, the State's plan for using encounter data to pursue health care quality improvement must describe how the data will be used to study the following priority areas:

- diabetes;
- prenatal care and birth outcomes;
- asthma;
- and two additional clinical conditions to be determined by the State based upon the population(s) served.

ATTACHMENT A

GENERAL FINANCIAL REQUIREMENTS

1. The State shall provide quarterly expenditure reports using the Form CMS-64 to separately report expenditures for services provided under the Medicaid program and those provided through Managed Care Plus (MC+) under section 1115 authority. CMS will provide Federal Financial Participation (FFP) only for allowable MC+ expenditures that do not exceed the expenditure limits as specified in Attachment D.

2. a. In order to track expenditures under this demonstration, the State will report MC+ demonstration expenditures through the Medicaid Budget and Expenditure System (MBES), following routine CMS-64 reporting instructions outlined in Section 2500 of the State Medicaid Manual. Expenditures subject to the budget neutrality limit (described in Attachment D) for the populations defined in item 3 will be differentiated from other Medicaid expenditures by identifying them on separate Forms CMS-64.9 and/or 64.9p, with the demonstration project number assigned by CMS (including the project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made). For monitoring purposes, cost settlements attributable to expenditures subject to the budget neutrality cap must be recorded on Line 10.b, in lieu of Lines 9 or 10.c. For any other cost settlements (i.e., those not attributable to this demonstration), the adjustments should be reported on lines 9 or 10.c, as instructed in the State Medicaid Manual.

   b. For each demonstration year, three separate CMS-64.9 Waiver and/or 64.9p Waiver should be submitted reporting expenditures subject to the budget neutrality cap. On the first form, all expenditures for the adult expansion populations (as defined in 3) shall be reported. On the second form, all expenditures for the children expansion populations (as defined in 3) shall be reported. On the third form, all expenditures for health care for the indigent in St. Louis made by the St. Louis Regional Disproportionate Share Hospital Authority shall be reported. The sum of these sheets and the DSH expenditures should represent the expenditures subject to the budget neutrality cap reported in that quarter. The term, "expenditures subject to the budget neutrality cap" includes all DSH expenditures and all Medicaid expenditures on behalf of the MC+ populations under the demonstration and expenditures for health care for the indigent in St. Louis made by the Regional Disproportionate Share Hospital Authority.

   c. Administrative costs will not be included in the budget neutrality limit, but the State must separately track and report additional administrative costs that are attributable to the demonstration. Procedures regarding the tracking and reporting of administrative costs will be described in the Operational Protocol, to be submitted by the State to CMS under terms specified in Attachment F.

   d. All claims for expenditures subject to the budget neutrality cap (including any cost settlements) must be made within two years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the

demonstration period (including any cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the 1115 demonstration on the Form CMS-64 in order to properly account for these expenditures in determining budget neutrality.

e. At the beginning and end of the demonstration the entire FFY DSH expenditure should not be applied to the budget neutrality limit. Therefore, expenditures subject to the cap will be determined by prorating FFY DSH expenditures to reflect the portion of the FFY during which the demonstration was operational (Attachment D includes an example).

f. The procedures related to this reporting process will be detailed in the Operational Protocol.

g. The procedures related to this reporting process will be detailed in the Operational Protocol.

3. For the purpose of this demonstration, MC+ population includes:

a. Uninsured children with family income up to 300% FPL

b. Adults transitioning off of welfare (TANF), who would otherwise not be insured or Medicaid eligible, with family income up to 300% FPL (coverage will be time limited, with a commercially-oriented benefit package and participation premiums)

c. Uninsured non-custodial parents with family income up to 100% FPL who are current in paying their child support

d. Uninsured non-custodial parents actively participating in Missouri's Parents' Fare Share program

e. Uninsured custodial parents with family income up to 100% FPL

f. Uninsured women losing their Medicaid eligibility 60 days after the birth of their child would be eligible for women's health services, regardless of income level, for two years

4. The standard Medicaid funding and reporting processes will be used during the demonstration. Missouri must continue to estimate matchable expenditures for the entire program (including the State plan and the Managed Care Plus) on the quarterly Form CMS-37. The State must provide supplemental schedules that clearly distinguish between estimates of expenditures subject to the budget neutrality cap (by major component) and estimates of expenditures that are not subject to the cap. CMS will make Federal funds available each quarter based upon the State's estimates, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in

the quarter just ended. CMS will reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the State for that quarter, and include the reconciling adjustment in a separate grant award to the State.

5. CMS will provide Federal Financial Participation (FFP) at the applicable Federal matching rate for the following, subject to the limits described in Attachment D:

   a. Administrative costs, including those associated with the administration of the Managed Care Plus demonstration;

   b. Net expenditures and prior period adjustments which are paid in accordance with the approved State plan (including disproportionate share hospital payments); and

   c. Net medical assistance expenditures made under Section 1115 and 1915 waiver authority, including those made in conjunction with the Managed Care Plus demonstration.

6. The State will certify that State/local monies used as matching funds for Managed Care Plus purposes will not be used as matching funds for any other Federal grant or contract, except as permitted by Federal law.

7. If the State elects to amend its demonstration to include coverage for the Title XXI eligible children at the regular Medicaid matching rate after Title XXI allocation are expended, it will be necessary to create a budget neutrality cap for this population under the 1115 demonstration. When the state does begin to draw down regular Title XIX matching funds for this population, the section 1115 budget neutrality cap would be based on the state's actual experience with its Title XXI program. The base year cost per member per month will be the state's actual per member per month cost under the Title XXI program during the most recent 12 month period for which there is complete data. Assuming that the state has at least 3 years' experience with the Title XXI program, CMS will use this experience to determine the growth rate that would be applied to the above base year in order to establish the budget neutrality cap for the waiver population for the remainder of the initial waiver period. Trend rates beyond year five would be negotiated as part of the waiver renewal process.

8. Funds currently provided to St. Louis by the State through the General Assistance Program and Certified Local Funds will be maintained at current levels.

ATTACHMENT B

GENERAL PROGRAM REQUIREMENTS

1. To be included as part of the State's contract with an MCO, the State shall require MCOs to protect the confidentiality of all project-related information that identifies individuals. The provisions must specify that such information is confidential and, that it may not be disclosed directly or indirectly except for purposes directly connected with the conduct of the project or the administration of the Medicaid program, including evaluations conducted by the independent evaluator selected by the State and/or CMS, or evaluations performed or arranged by State agencies. Written consent of the individual must be obtained for any other disclosure.

2. The State's MCO contracts and subcontracts for services related to MC+ must provide that the State agency and the U.S. Department of Health and Human Services may: (1) evaluate through inspection or other means the quality, appropriateness, and timeliness of services performed and (2) inspect and audit any financial records, including reimbursement rates, of such contractor/subcontractors.

3. CMS may contract with an independent contractor to evaluate the demonstration. The State agrees to cooperate with the evaluator (at no cost), by responding in a timely manner to requests for interviews, providing access to records, and sharing data, including the claims, encounter, and eligibility files. The State has the right to review reports and the right to comment on reports prepared by the evaluator.

4. CMS may suspend or terminate any project in whole or in part at any time before the date of expiration, whenever it determines that the State has materially failed to comply with the terms of the project. CMS will promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date. The State waives none of its rights under 42 CFR 430, Grants to States for Medical Assistance Programs, to challenge CMS's finding that the State materially failed to comply. CMS reserves the right to withhold waivers pending or to withdraw waivers at any time if it determines that granting or continuing the waivers would no longer be in the public interest. If the waiver is withdrawn, CMS will be liable for only normal close-out costs.

5. The State may suspend or terminate this demonstration in whole or in part at any time before the date of expiration. The State will promptly notify CMS in writing of the reasons for the suspension or termination, together with the effective date. If the waiver is withdrawn, CMS will be liable for only normal close-out costs.

ATTACHMENT C

GENERAL REPORTING REQUIREMENTS

1. By April 1 of each year, the State will submit Form CMS-416, EPSDT program reports for the previous Federal fiscal year. These reports will follow the format specified in section 2700.4 of the State Medicaid Manual, with data for each line item arrayed by age group and basis of eligibility. All data reported will be supported by documentation consistent with the general requirements of these terms and conditions.

2. Through the first six months after implementation, CMS and the State will hold monthly calls to discuss progress. Further, at the end of the first six months, the State will submit quarterly progress reports which are due 60 days after the end of each quarter. The reports should include, as appropriate, a discussion of events occurring during the quarter that affect health care delivery, including access to in-plan services and to out-of-plan services; the enrollment process for the new eligible adults, the mental health and substance abuse coordination under the demonstration; enrollment and outreach activities; default assignments; quality of care; access; MCO financial performance; complaints and appeals to the State; beneficiary telephone hot line performance; the referral system; the benefit package(s); and other operational and policy issues. The report should include a separate discussion of State efforts related to the collection and verification of encounter data. The report should also include proposals for addressing any problems identified in each report.

3. The State will submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, and policy and administrative difficulties no later than 120 days after the end of its operational year. Within 30 days of receipt of comments from CMS, a final annual report will be submitted.

4. At the end of the demonstration, a draft final report should be submitted to CMS for comments. CMS's comments must be taken into consideration by the State for incorporation into the final report. The State should use CMS’s Office of Research and Demonstrations' Author's Guidelines: Grants and Contracts Final Reports (copy attached) in the preparation of the final report. The final report is due no later than 90 days after the termination of the project.

5. The State will submit a phase-out plan of the demonstration to CMS six months prior to initiating normal phase-out activities or, if desired by the State, an extension plan on a timely basis to prevent disenrollment of members if the waiver is extended by CMS. Nothing herein shall be construed as preventing the State from submitting a phase-out plan with an implementation deadline shorter than six months when such action is necessitated by emergency circumstances. The phase-out plan is subject to CMS review and approval.

6. The State shall submit a continuation application 270 days after the effective date of the award and yearly thereafter.

7. To assist CMS in monitoring the waiver, the State will provide the following information:

- Indicators of HMO operations (Submission of Region VII Regional Profile data in all categories);

ATTACHMENT D

MONITORING BUDGET NEUTRALITY FOR THE
Missouri State Demonstration

The following describes the method by which budget neutrality will be assured under the Managed Care Plus (MC+) Demonstration. Missouri will be subject to a limit on the amount of Federal Title XIX funding that the State may receive on selected Medicaid expenditures during the demonstration period.

For the purpose of calculating the overall expenditure limit for the demonstration, separate budget estimates will be calculated for each Federal Fiscal Year (FFY) on a demonstration year (DY) basis. Each annual estimate shall be an estimate of disproportionate share hospital (DSH) expenditures. The annual estimates will then be prorated and added together to obtain an expenditure estimate for the entire demonstration period. The Federal share of this estimate will represent the maximum amount of FFP that the State may receive during the 5-year period for regular DSH, MC+ expenditures, and expenditures for health care for the indigent in St. Louis amendment made by the Regional Disproportionate Share Hospital Authority described below. For each DY, the Federal share will be calculated using the Federal medical assistance percentage (FMAP) rate(s) applicable to that year.

DSH Expenditure Limit

The annual DSH expenditure limit for the demonstration will be calculated using an aggregate cost method, in which BBA DSH allotments are reduced by the Title XXI allotments. For DY 2003 and beyond, BBA guidelines for establishing DSH allotments will apply.

Developing the Demonstration budget estimate

Because the beginning of the demonstration is unlikely to coincide with the beginning of the FFY, the overall expenditure limit for the demonstration will include portions of six FFYs. The limit will exclude portions of the beginning and ending FFY periods when the demonstration is not operational. For example, for operations beginning September 1, 1998, adjustments would apply as follows:

FFY	Portion of the Adjusted BBA DSH Allotment to include in the limit	BBA DSH Allotment*	Adjusted DSH Amount*	BBA Title XXI Allotment*	5- year Budget Limit
1998	8%(1/12=.08)	$436	$ 35		
1999	100%(11/12+1/12=1.00)	$423	$ 423		
2000	100%(11/12+1/12=1.00)	$379	$ 379		
2001	100%(11/12+1/12=1.00)	$379	$ 379		
2002	100%(11/12+1/12=1.00)	$379	$ 379		
2003	92%(11/12=.92)	$379	$ 349		
			$ 1,944	$ 290**	$ 1,654***

*The amounts above represent Federal Share in millions of dollars.
**Missouri's estimate from page 98 of the letter dated December 17, 1997. Actual allotments will be used when published.
***Adjusted DSH amount minus Title XXI estimates.

Taxes and Donations

The State shall file an amended administrative rule that governs payments to designated payees. The rule will be in accordance with the rulemaking description in the March 6, 1998 response concerning representative payees and Missouri's Federal Reimbursement Allowance and Nursing Facility Reimbursement Allowance and will prohibit unaffiliated providers from designating a common business agent. Any necessary enabling rulemaking must be in effect before the MC+ demonstration draws any Federal funds under the terms of this waiver program. If any health care related tax which was in effect during the base period, or provider related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of 1903(w) of the Social Security Act, CMS reserves the right to make adjustments to the budget neutrality cap.

How the Limit Will Be Applied

The limit calculated above will apply to actual expenditures, as reported by the State under Attachment A. If at the end of the demonstration period the budget neutrality provision has been exceeded, the excess Federal funds will be returned to CMS. There will be no new limit placed on the FFP that the State can claim for expenditures for recipients and program categories not listed. If the demonstration is terminated prior to the 5-year period, the budget neutrality test will be prorated based on the time period through the termination date.

Expenditure Review

CMS shall enforce budget neutrality over the life of the demonstration, rather than on an annual basis. However, no later that six months after the end of each demonstration year, the CMS will calculate an annual expenditure target for the completed year. This amount will be compared with the actual FFP claimed by the State under budget neutrality. If the State exceeds the cumulative target, they shall submit a corrective action plan to CMS for approval. The State will subsequently implement the approved program.

Year	Cumulative target definition	Percentage
Year 1	Year 1 budget neutrality cap plus	8 percent
Year 2	Years 1 and 2 combined budget neutrality cap plus	3 percent
Year 3	Years 1 through 3 combined budget neutrality cap plus	1 percent
Year 4	Years 1 through 4 combined budget neutrality cap plus	0.5 percent
Year 5	Years 1 through 5 combined budget neutrality cap plus	0 percent

Special Requirements for the "Health Care for the Indigent of St. Louis" Amendment

Missouri's request is to spend an estimated 9.89% of the Federal share of the statewide disproportionate share hospital (DSH) spending for acute care hospitals. Therefore, expenditures under this amendment will be limited to 9.89% (Federal share) of the statewide DSH spending for acute care hospitals for each remaining year of the demonstration. Missouri must continue to comply with hospital specific limits as provided in OBRA 1993.

During each Federal fiscal year of the demonstration period, Federal match for demonstration and DSH expenditure claims will be limited by current law DSH allotments less the Title XXI allotment. Because the beginning of the demonstration is unlikely to coincide with the beginning of the Federal fiscal year, expenditures subject to the cap will be determined by prorating FFY expenditures to reflect the portion of the FFY during which the demonstration was operational. If at the end of the demonstration period the budget neutrality provision has been exceeded, the excess Federal funds will be returned to CMS. If the demonstration is terminated prior to the end of the approved demonstration period, the budget neutrality test will be prorated based on the time period through the termination date.

ATTACHMENT E

CONTRACTORS' ACCESS STANDARDS

Contractors shall provide available, accessible, comprehensive quality care to eligible beneficiaries through the use of an adequate number of institutional facilities, service locations, service sites, and professional, allied, and paramedical personnel for the provision of all covered services. These services must be available on an emergency basis, 24-hours-a-day, 7-days-a-week. Unless Missouri can demonstrate that they surpass the following standards, at a minimum, the standards for making this care available shall include:

1. Primary Care

a. Distance: The enrollees in urban/suburban areas shall be within 20 miles of a PCP. In rural areas, the usual and customary standards shall apply. Usual and customary should be defined as: access that is equal to or greater than the currently existing practice in the fee-for-service system.

b. Appointment Times: Not to exceed 30 calendar days for non-symptomatic office visits; 48 hours for urgent office visits; and same day appointments for emergency office visits.

d. Waiting Times: Beneficiaries with appointments shall not routinely be made to wait longer than one hour.

e. Tracking: All MCOs must have a system in place for confidential exchange of beneficiary information with the primary care provider if a provider other than the primary care provider delivers health care services to the beneficiary.

2. Specialty Care

Referral appointments to specialists, except for specialists providing mental health and substance abuse services, (e.g., specialty physician services, hospice care, home health care, and certain rehabilitation services, etc.) shall not exceed 30 days for routine care or 72 hours for urgent care.

3. Emergency Care/Shock Trauma

All emergency care must be provided on an immediate basis, at the nearest equipped facility available, regardless of contract affiliation.

4. Hospitals

The enrollees in urban/suburban areas shall be within 20 miles of a hospital. In rural areas, the usual and customary standards shall apply..

5. Pharmacy Services

Urban/suburban enrollees shall be within 20 miles of a pharmacy. In rural areas, the usual and customary standards shall apply.

6. Other

All other services not specified here shall meet the usual and customary practice standards for the community. Such services shall include, but not be limited to,

laboratory and x-ray services.

7. **Documentation**

All entities providing care to beneficiaries (MCOs, specialists, etc.) must have a general system in place to document adherence to the appropriate access standards (e.g. physician waiting times and appointment waiting times). The State must utilize statistically valid sampling methods for monitoring compliance with these standards (e.g. beneficiary and provider survey).

ATTACHMENT F

OPERATIONAL PROTOCOL

The State will be responsible for developing a detailed protocol describing the MC+ demonstration. The protocol will serve as a stand alone document that reflects the operating policies and administrative guidelines in the demonstration. The protocol will be submitted for approval no later than 60 days prior to implementation. CMS will respond within 30 days of receipt of the protocol. The State shall assure and monitor compliance with the protocol. The protocol will include all requirements specified within the Special Terms and Conditions to include:

1. The organizational and structural administration that will be in place to implement, monitor, and run the demonstration, and the tasks that each will perform.

2. The organization of managed care networks and the criteria procedures for determining adequate managed care provider capacity by county, as well as the process and criteria applied for provider selection.

3. A complete description of Medicaid services covered under the demonstration, including those subject to capitation and those otherwise reimbursed.

4. A detailed plan for monitoring the State's coordination of care, utilization, and payment for out-of-plan services.

5. Marketing and outreach strategies including the permissible marketing activities by MCOs and a complete description of the enrollment broker.

6. A description of the State's beneficiary education process.

7. A comprehensive description of the enrollment and disenrollment process with specifics on the default assignment process.

8. Selection policies and MCO contracting requirements.

9. Capitation (including risk adjustments), incentive plans, and claims payment mechanisms.

10. MCO financial and solvency reporting, and monitoring requirements, including standards for timeliness of claims payment.

11. An overall quality assurance monitoring plan that includes a discussion of all quality indicators to be employed and methodology for measuring such indicators; surveys to be conducted, and the monitoring and corrective action plans to be triggered by the surveys; the credentialing requirements and monitoring; fraud control provisions and monitoring; and the proposed provider-enrollee ratios, access standards, etc.

12. Submit a minimum data set, and a description showing how collection of plan encounter data is being implemented and monitored; measures that will be in place for ensuring accuracy, validity, and timely submission of data; what resources will be assigned to this

effort; and how the State will use the encounter data to monitor implementation of the project and feed findings directly into program change on a timely basis.

13. The complaint, grievance, and appeal policies that will be in place at the State and MCO level.

14. Basic features of the administrative and management data system.

15. Description of all referral authorization plans, and policies and procedures relating to them.

16. Description of how beneficiary access will be guaranteed in case of termination of the MCO contract.

17. Description of the behavioral health referral system, including process, timelines, information exchange, compliant procedure, and a plan for monitoring the efficiency of the system.

ATTACHMENT G

CMS **Encounter Data Set Elements**

ELEMENTS	TYPE OF RECORD			
	PHYS & OTHER PROVS	HOSP	LTC	DRUGS
Beneficiary/Enrollee ID	X	X	X	X
Beneficiary/Enrollee Name	X	X	X	X
Beneficiary/Enrollee DOB	X	X	X	X
Plan ID	X	X	X	X
Physician/Supplier/Provider ID	X	X	X	X
Attending/Ordering/Referring Performing Physician ID	X	X	X	X
Provider Location Code/Address	X	X	X	X
Place of Service Code	X	X	X	-
Specialty Code	X	-	X	-
Date(s) of Service	X	X	X	X
Units of Service/Quantity	X	X	X	X
Principal Diagnosis Code	X	X	-	-
Other Diagnosis Code(s)	X	X	-	-
Procedure Code	X	X	X	-
EPSDT Indicator	X	-	-	-
Patient Status Code	-	X	X	-
Revenue Code	-	X	X	-
National Drug Code	-	-	X	X